EXHIBIT A

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixson

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

SOUTHEAST MICHIGAN SURGICAL HOSPITAL, LLC, SPINE PLLC, SUMMIT MEDICAL GROUP, PLLC, SUMMIT PHYSICIANS GROUP, PLLC, GETTER DONE TRANSPORTATION, LLC, and KEVIN T. CRAWFORD, DO, PC,

Plaintiffs,

vs.

MAURICE LITTLE,

Defendant.
_____/

Case No. 18-014385-CK
Hon: John H. Gillis

PAUL J. WHITING III (P61570)
STEVEN M. BRAUN (P79461)
WHITING LAW
Attorneys for Plaintiff
26300 Northwestern Hwy, Ste. 301
Southfield, MI 48076
(248)355-5900/(248)355-5901
steven.braun@844whiting.com
paul.whiting@844whiting.com
_____/

PLAINTIFFS' SECOND AMENDED COMPLAINT

NOW COMES Plaintiffs, SOUTHEAST MICHIGAN SURGICAL HOSPITAL, LLC, SPINE PLLC, SUMMIT MEDICAL GROUP, PLLC, SUMMIT PHYSICIANS GROUP, PLLC, GETTER DONE TRANSPORTATION, LLC, KEVIN T. CRAWFORD DO, PC, (hereinafter collectively "Plaintiffs") by and through their attorneys, WHITING LAW, and for their Complaint against Defendant, MAURICE LITTLE, state as follows:

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JURISDICTIONAL ALLEGATIONS

1. Plaintiff, Southeast Michigan Surgical Hospital, LLC (hereinafter "SEMSH"), is a Michigan limited liability corporation, doing business in the County of Macomb, State of Michigan.

2. Plaintiff, Spine PLLC (hereinafter "Spine"), is a Michigan professional limited liability corporation, doing business in the County of Oakland, State of Michigan.

3. Plaintiff, Summit Medical Group, PLLC (hereinafter "SMG"), is a Michigan professional limited liability corporation, doing business in the County of Wayne, State of Michigan.

4. Plaintiff, Summit Physicians Group, PLLC (hereinafter "SPG"), is a Michigan professional limited liability corporation, doing business in the County of Wayne, State of Michigan.

5. Plaintiff, Getter Done Transportation, LLC (hereinafter "GTD"), is a Michigan limited liability corporation, doing business in the County of Oakland, State of Michigan.

6. Plaintiff, Kevin T. Crawford, DO, PC (hereinafter "CRAWFORD"), is a Michigan professional corporation, doing business in the County of Wayne, State of Michigan.

7. Defendant, Maurice Little (hereinafter "Defendant") is believed to be a resident of the City of Davenport, County of Scott, State of Iowa.

8. Plaintiffs Southeast Michigan Surgical Hospital, LLC, Spine PLLC, Summit Medical Group, PLLC, Summit Physicians Group, PLLC, and Dr. Kevin T. Crawford, DO, PC are health care providers who provided care, treatment, and/or services to Defendant.

9. Furthermore, Plaintiff Getter Done Transportation, LLC, is a transportation provider who provided medical transportation to Defendant.

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10. That the amount in controversy is in excess of Twenty-Five Thousand Dollars ($25,000.00) and within the jurisdiction of this Court.

GENERAL ALLEGATIONS

11. Plaintiffs reincorporate and reallege paragraphs 1 through 10 as if fully set forth herein.

12. That on or about October 2, 2015, Defendant was involved in a serious motor vehicle accident wherein he sustained injuries that required medical care from Plaintiffs.

13. That as a result of that motor vehicle accident Defendant became entitled to Michigan No Fault benefits to pay for his care, recovery and rehabilitation.

14. That Non-Party Farm Bureau was the insurance company to pay for Defendant's medical care arising out of said motor vehicle accident.

15. That Non-Party Farm Bureau refused to pay for Defendant's No-Fault benefits necessitating Defendant to file a lawsuit against Non-Party Farm Bureau.

16. That on the eve of trial in that matter, Defendant and Non-Party Farm Bureau settled the claim with Non-Party Farm Bureau agreeing to defend and indemnify Defendant from Plaintiffs claims (***Exhibit 1*** — **Release Executed by Defendant**):

> IT IS FURTHER EXPRESSLY AGREED that Farm Bureau will defend and indemnify **Maurice Little** from any and all claims, judgments, and liens asserted against **Maurice Little** by any healthcare or other medical provider, or any other person or entity, including but not limited to, Medicare and/or Medicaid, the Centers for Medicare and Medicaid Services, and the Medicare or Medicaid Secondary Payer Contractors and/or their agents, affiliates, or assignees, for any unpaid bills, invoices, or expenses of any type emanating from the injuries and claims made by **Maurice Little** in connection with the aforementioned accident and that were or could have been brought in the above referenced lawsuit.

17. That there is no dispute that Plaintiffs provided the claimed services to Defendant and that these services were for his care, recovery and rehabilitation resulting from injuries he

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suffered in the motor vehicle accident. (***Exhibit 2*** — **Affidavit of Maurice Little Signed 4/20/18**).

18. That there is no dispute that Defendant received and acknowledges liability for each of Plaintiffs' attached bills. (***Exhibit 2*** — **Affidavit of Maurice Little Signed 4/20/18 and *Exhibits 3A through 3F*** — **Billing Statements of Plaintiffs**).

19. That Non-Party Farm Bureau is aware of Plaintiffs bills and has refused to pay said bills.

20. That Defendant has not paid any of the incurred bills from any Plaintiff.

COUNT I –
PLAINTIFF SEMSH CLAIM AGAINST DEFENDANT

21. Plaintiff "SEMSH" reincorporates and realleges paragraphs 1 through 20 as if fully set forth herein.

22. Plaintiff "SEMSH" rendered and provided care, treatment, and/or services to Defendant and for which Defendant acknowledges the aforementioned care, treatment, and services were provided relating to his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (***Exhibit 2*** — **Affidavit of Maurice Little Signed 4/20/18**).

23. That the services rendered by Plaintiff were reasonably necessary for Defendant's care, recovery or rehabilitation.

24. That Plaintiff "SEMSH" has incurred $544,369.64 in medical bills for services rendered to Defendant. (***Exhibit 3A*** — **Billing Statement of SEMSH**).

25. That Defendant has failed to pay Plaintiff "SEMSH" for the services it rendered.

26. That Plaintiff "SEMSH" is entitled to a judgement against Defendant in the amount of $544,369.64, plus interest and attorney fees. (***Exhibit 3A*** — **Billing Statement of SEMSH**).

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COUNT II –
PLAINTIFF SPINE CLAIM AGAINST DEFENDANT

27. Plaintiff "SPINE" reincorporates and realleges paragraphs 1 through 26 as if fully set forth herein.

28. Plaintiff "SPINE" rendered and provided care, treatment, and/or services to Defendant and for which Defendant acknowledges the aforementioned care, treatment, and services were provided relating to his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (***Exhibit* 2 — Affidavit of Maurice Little Signed 4/20/18**).

29. That the services rendered by Plaintiff were reasonably necessary for Defendant's care, recovery or rehabilitation.

30. That Plaintiff "SPINE" has incurred $372,904.00 in medical bills for services rendered to Defendant. (***Exhibit 3B* — Billing Statement of SPINE**).

31. That Defendant has failed to pay Plaintiff "SPINE" for the services it rendered.

32. That Plaintiff "SPINE" is entitled to a judgement against Defendant in the amount of $372,904.00, plus interest and attorney fees. (***Exhibit 3B* — Billing Statement of SPINE**).

COUNT III –
PLAINTIFF SMG CLAIM AGAINST DEFENDANT

33. Plaintiff "SMG" reincorporates and realleges paragraphs 1 through 32 as if fully set forth herein.

34. Plaintiff "SMG" rendered and provided care, treatment, and/or services to Defendant and for which Defendant acknowledges the aforementioned care, treatment, and services were provided relating to his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (***Exhibit* 2 — Affidavit of Maurice Little Signed 4/20/18**).

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35. That the services rendered by Plaintiff were reasonably necessary for Defendant's care, recovery or rehabilitation.

36. That Plaintiff "SMG" has incurred $270.00 in medical bills for services rendered to Defendant. (***Exhibit 3C*** **— Billing Statement of SMG**).

37. That Defendant has failed to pay Plaintiff "SMG" for the services it rendered.

38. That Plaintiff "SMG" is entitled to a judgement against Defendant in the amount of $270.00, plus interest and attorney fees. (***Exhibit 3C*** **— Billing Statement of SMG**).

COUNT IV –
PLAINTIFF SPG CLAIM AGAINST DEFENDANT

39. Plaintiff "SPG" reincorporates and realleges paragraphs 1 through 38 as if fully set forth herein.

40. Plaintiff "SPG" rendered and provided care, treatment, and/or services to Defendant and for which Defendant acknowledges the aforementioned care, treatment, and services were provided relating to his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (***Exhibit*** **2 — Affidavit of Maurice Little Signed 4/20/18**).

41. That the services rendered by Plaintiff were reasonably necessary for Defendant's care, recovery or rehabilitation.

42. That Plaintiff "SPG" has incurred $138,306.50 in medical bills for services rendered to Defendant. (***Exhibit 3D*** **— Billing Statement of SPG**).

43. That Defendant has failed to pay Plaintiff "SPG" for the services it rendered.

44. That Plaintiff "SPG" is entitled to a judgement against Defendant in the amount of $138,306.50, plus interest and attorney fees. (***Exhibit 3D*** **— Billing Statement of SPG**).

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COUNT V –
PLAINTIFF GTD CLAIM AGAINST DEFENDANT

45. Plaintiff "GTD" reincorporates and realleges paragraphs 1 through 44 as if fully set forth herein.

46. Plaintiff "GTD" provided transportation services to Defendant and for which Defendant acknowledges the need for transportation was the direct result of his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (***Exhibit* 2 — Affidavit of Maurice Little Signed 4/20/18**).

47. That the services rendered by Plaintiff were reasonably necessary for Defendant's care, recovery or rehabilitation.

48. That Plaintiff "GTD" has incurred $$7,455.00 in transportation bills for services rendered to Defendant. (***Exhibit 3E* — Billing Statement of GTD**).

49. That Defendant has failed to pay Plaintiff "GTD" for the services it rendered.

50. That Plaintiff "GTD" is entitled to a judgement against Defendant in the amount of $7,455.00, plus interest and attorney fees. (***Exhibit 3E* — Billing Statement of GTD**).

COUNT IV –
PLAINTIFF CRAWFORD CLAIM AGAINST DEFENDANT

51. Plaintiff "CRAWFORD" reincorporates and realleges paragraphs 1 through 50 as if fully set forth herein.

52. Plaintiff "CRAWFORD" rendered and provided care, treatment, and/or services to Defendant and for which Defendant acknowledges the aforementioned care, treatment, and services were provided relating to his motor-vehicle accident injuries to his neck, back, shoulder, knee, and hip. (***Exhibit* 2 — Affidavit of Maurice Little Signed 4/20/18**).

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53. That the services rendered by Plaintiff were reasonably necessary for Defendant's care, recovery or rehabilitation.

54. That Plaintiff "CRAWFORD" has incurred $12,566.00 in medical bills for services rendered to Defendant. (***Exhibit 3F*** **— Billing Statement of CRAWFORD**).

55. That Defendant has failed to pay Plaintiff "CRAWFORD" for the services it rendered.

56. That Plaintiff "CRAWFORD" is entitled to a judgement against Defendant in the amount of $12,566.00 plus interest and attorney fees. (***Exhibit 3F*** **— Billing Statement of CRAWFORD**).

WHEREFORE, Plaintiffs pray for a Judgment against the Defendant, for the medical expenses that have been incurred, as applicable, in an amount in excess of **$1,075,871.14**, together with costs and attorney fees so wrongfully sustained and interest to the date of judgment.

Respectfully Submitted,

PAUL J. WHITING III (P61570)
STEVEN M. BRAUN (P79461)
Attorneys for Plaintiff
26300 Northwestern Hwy, Ste. 301
Southfield, MI 48076
(248)355-5900/(248)355-5901–Fax
steven.braun@844whiting.com

Dated: November 8, 2018

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Exhibit 1

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SETTLEMENT AGREEMENT AND RELEASE

IT BEING THE INTENT of the parties hereto that certain claims for No-Fault Benefits be fully and finally resolved by this instrument, the claimant, **Maurice Little**, subscribes as follows:

I, **Maurice Little**, for the sole consideration of **THIRTY-FIVE THOUSAND AND 00/100 ($35,000.00) DOLLARS**, to me in hand paid, receipt of which is hereby acknowledged do hereby for myself and for my heirs, executors, administrators, and assigns, release, acquit, and forever discharge FARM BUREAU INSURANCE COMPANY (hereinafter "Farm Bureau"), its officers, employees, agents, or lawyers, from all claims, damages, demands, or causes of action, incurred by or on behalf of **Maurice Little,** including but not limited to:

1. All claims for past, present, and future allowable expenses incurred because of the subject accident, which occurred on February 14, 2015, and is the subject of *Maurice Little v Farm Bureau*, Case No. 16-001973-NF, in the Wayne County Circuit Court;

2. All claims for past, present, and future Wage Loss incurred because of the subject accident, which occurred on February 14, 2015;

2. All claims for past, present, and future Household Replacement Services incurred because of the subject accident, which occurred on February 14, 2015;

3. All claims for past, present, and future Attendant Care Services incurred because of the subject accident, which occurred on February 14, 2015;

4. All claims for past, present, and future medical expenses incurred because of the subject accident, which occurred on February 14, 2015;

5. Any and all interest charges as provided under the No-Fault Statute (MCL 500.3101, et seq.);

6. Any and all interest charges as provided by the Revised Judicature Act, MCL 600.101, et seq.; and

7. Any and all reasonable attorney fees that may be owed to the attorneys for **Maurice Little** as provided by the No-Fault Statute, MCL 500.3101, et seq., as a consequence of the representation of **Maurice Little**;

I have represented that the injuries sustained are permanent and progressive, and that recovery therefrom is uncertain and indefinite, and in making this Settlement Agreement and Release, it is understood and agreed that I rely wholly upon my own judgment, belief, and knowledge of the nature, extent, and duration of said injuries and damages and that no representations or statements regarding said injuries and damages or regarding any other matters made by the persons, firms, or corporations who are hereby released, or any person or persons representing them or by any physician or surgeon by them employed, has influenced me to any extent whatsoever in making this Release.

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IT IS FURTHER EXPRESSLY AGREED that Farm Bureau will defend and indemnify **Maurice Little** from any and all claims, judgments, and liens asserted against **Maurice Little** by any healthcare or other medical provider, or any other person or entity, including but not limited to, Medicare and/or Medicaid, the Centers for Medicare and Medicaid Services, and the Medicare or Medicaid Secondary Payer Contractors and/or their agents, affiliates, or assignees, for any unpaid bills, invoices, or expenses of any type emanating from the injuries and claims made by **Maurice Little** in connection with the aforementioned accident and that were or could have been brought in the above referenced lawsuit.

IT IS FURTHER UNDERSTOOD that no promise, inducement or agreement not herein expressed has been made to the undersigned, and that this Release contains the entire agreement between the parties hereto, and that the terms of this Release are contractual and not a mere recital.

IT IS AGREED that this settlement is a compromise of a doubtful and disputed claim or claims and that any payment or payments made hereunder are not to be construed as an admission of liability or indebtedness on the part of Farm Bureau, by whom all liability or indebtedness is expressly denied. No terms or conditions contained with any check or draft tendered in satisfaction hereof shall modify, alter or expand the terms and conditions of this Release.

IT IS FURTHER AGREED that if any medical provider with whom I sought treatment in connection with the above-referenced accident files suit against **Maurice Little**, he will waive any potential conflict of interest and will allow Farm Bureau to appoint counsel of its choosing to represent him, and will fully cooperate with that counsel and actively participate in defense of the action(s).

IT IS FURTHER AGREED that **Maurice Little** will sign an authorization allowing Farm Bureau, its employees, and attorneys, to publicly discuss his case and to release to others all documents related to his case, including but not limited to medical records and deposition transcripts.

All agreements and understandings between the parties hereto are embodied and expressed herein and the terms of this Settlement Agreement and Release are contractual and not a mere recital. **I HAVE READ THE FOREGOING SETTLEMENT AGREEMENT AND RELEASE AND FULLY UNDERSTAND IT.**

The terms of this release and settlement shall remain private and confidential, and shall not be disclosed to individuals or entities, other than agents or representatives of the parties hereto, without prior authorization from Farm Bureau.

IN WITNESS HEREOF, I have set my hand and seal this 20th day of April, 2018.

Maurice Little
MAURICE LITTLE

IN THE PRESENCE OF:

Michael J. McNamara
WITNESS

Subscribed and sworn to before me this 20th day of April, 2018.

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Notary Public, County of
My Commission Expires: 2/7/2024

DEBRA LEAPHEART
Notary Public, State of Michigan
County of Wayne
My Commission Expires 02-07-2024
Acting in the County of Wayne

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Exhibit 2

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AFFIDAVIT OF MAURICE LITTLE

I, Maurice Little, hereby state and affirm the following to be true under the penalty of perjury:

1. On February 14, 2015, I was a restrained rear seat passenger traveling on I-94 when we were rear-ended by a semi-truck totaling the vehicle.

2. That as a result of said motor vehicle accident I suffered injuries to my neck, back, shoulder, hip and other areas throughout my body that required medical treatment.

3. That for these injuries I sought medical treatment from the following medical facilities and/or medical providers:

   a. St. Joseph Mercy Hospital;
   b. Dr. Kevin Crawford;
   c. Dr. Jankowski;
   d. Summit Medical Group and its physicians;
   e. Summit Physicians Group, PLLC;
   f. ORA Orthopedics;
   g. Anesthesia Associations of Ann Arbor;
   h. Oakwood Healthcare Group;
   i. Drs. Harris, Birkhill, PC;
   j. Getter Done Medical Transportation;
   k. Auto RX;
   l. Detroit Bio Medical Laboratories;
   m. Radeas LLC;
   n. Expertus Laboratories, Inc.;
   o. Lab Geeks, LLC;
   p. Geriatric Care Associates, PLLC.;
   q. Mainwaring Pathology Group, PC.;
   r. Guardian Anesthesia Services, LLC.;
   s. Oakwood Annapolis Hospital;
   t. Oakwood Ambulatory, LLC;
   u. Regents of University of Michigan;
   v. OHI Physician Network;
   w. University of Michigan Health System;
   x. Spine PLLC and Dr. Jeffery Wingate;
   y. Southeast Michigan Surgical Hospital;

4. That both Medicare and Medicaid have paid medical expenses that were incurred as a result of medical treatment related to the injuries I sustained in the motor vehicle accident.

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5. That the medical treatment I received for my neck, back, shoulder, knee and hip, including but not limited to diagnostic testing, medication, injections, multiple surgeries, physical therapy, etc., were related to and necessary for my care, recovery and rehabilitation for injuries arising out of the motor vehicle accident.

6. That I acknowledge I received medical bills from each of the medical providers enumerated in paragraph #3 above.

7. That I acknowledge that I incurred all of the medical treatment provided by each medical provider enumerated in paragraph #3 above.

8. That I do not contest that I am solely responsible for payment of all the medical treatment provided by each of the medical providers enumerated in paragraph #3.

9. That I acknowledge that I testified in the matter of Maurice Little v. Farm Bureau and affirm that my testimony was and remains true and accurate.

I, Maurice Little, hereby swear and attest that the above is true and accurate.

Maurice Little 4-20-18

Maurice Little Date

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Exhibit 3A

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1 SOUTHEAST MI SURG HOSP	2	3a PAT. CNTL # SMAE1702	4 TYPE OF BILL
21230 DEQUINDRE ROAD		b. MED. REC. # M000115016	0111
WARREN MI 480912279		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
5864271000 5867590237		13 4257646	100516 100816	

8 PATIENT NAME		9 PATIENT ADDRESS				
a		a 1459 ANDREA ST				
b LITTLE MAURICE		b YPSILANTI	c MI	d 48198	e	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
08151964	M	100516	08	3	1	08	02	C5												

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a														a
b														b

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	80	3 00	A3	191744 52		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0120	ROOM BOARD SEMI			3	4500 00		1
2	0250	PHARMACY			114	1604 96		2
3	0270	MED SUR SUPPLIES			12	82 60		3
4	0272	STERILE SUPPLY			68	5482 82		4
5	0278	SUPPLY IMPLANTS			22	97662 00		5
6	0300	LABORATORY OR LAB			15	756 75		6
7	0320	DX X RAY			3	954 75		7
8	0360	OR SERVICES			1	75229 10		8
9	0370	ANESTHESIA			15	3851 25		9
10	0636	DRUGS DETAIL CODE	90732		2	277 04		10
11	0710	RECOVERY ROOM			3	1309 50		11
12	0771	VACCINE ADMIN	G0009		1	33 75		12
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23	0001	PAGE 001 OF 001	CREATION DATE	021617	TOTALS	191744 52		23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A MEDICARE		Y	Y			1962402354	A
B						57 OTHER PRV ID 230264	B
C							C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A LITTLE MAURICE	18	374723080A		A
B				B
C				C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		A
B		B
C		C

66 DX																							67
0	T84428A	Y	M961	Y	M5416	Y	M4806	Y	R0609	Y	Z23	Y	M1990	Y	Z885		Z880		I10				

69 ADMIT DX	T84428A	70 PATIENT REASON DX				71 PPS CODE	0460	72 ECI	Y798	Y	V499XXA			73

74	PRINCIPAL PROCEDURE CODE	PRINCIPAL PROCEDURE DATE	a. OTHER PROCEDURE CODE	a. OTHER PROCEDURE DATE	b. OTHER PROCEDURE CODE	b. OTHER PROCEDURE DATE	75
	0SG00A1	100516	01NB0ZZ	100516	0QP004Z	100516	

c. OTHER PROCEDURE CODE	c. OTHER PROCEDURE DATE	d. OTHER PROCEDURE CODE	d. OTHER PROCEDURE DATE	e. OTHER PROCEDURE CODE	e. OTHER PROCEDURE DATE
4A11X4G	100516				

76 ATTENDING	NPI 1235117524	QUAL	
LAST WINGATE		FIRST JEFFREY	
77 OPERATING	NPI 1235117524	QUAL	
LAST WINGATE		FIRST JEFFREY	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a	B3	282N00000X
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. NUBC National Uniform Billing Committee 1C0213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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Exhibit 3B

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MEDICARE
P O BOX 5533
MARION IL 62959

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
X (Medicare#)	(Medicaid#)	(ID#/DoD#)	(Member ID#)	(ID#)	(ID#)	(ID#)	374723080A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
LITTLE MAURICE L	08151964 M X F	LITTLE, MAURICE, L
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1459 ANDREA STREET	Self X Spouse Child Other	1459 ANDREA STREET
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
YPSILANTI / MI		YPSILANTI / MI
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
48198 (313) 718 4781		48198 ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
LITTLE, MAURICE, L		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
		08151964 M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? X YES NO PLACE (State) MI	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
		ADJ: SHERRIL KRAUSMAN
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
02142015 QUAL.	QUAL.	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI 1134329493	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
DR JEFFREY K WINGATE		FROM 10052016 TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES X NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	ICD Ind. 0	22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. M5416 B. M5126 C. D.		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		
I. J. K. L.		

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
L3 L4											
10052016	10052016	21		22633		AB	1847700	1		NPI	1235117524
L2											
10052016	10052016	21		63005	59	AB	1820000	1		NPI	1235117524
L3											
10052016	10052016	21		63047		AB	1805200	1		NPI	1235117524
L5 S1											
10052016	10052016	21		63042	59	AB	2606400	2		NPI	1235117524
L5 S1											
10052016	10052016	21		22612		AB	1594800	1		NPI	1235117524
10052016	10052016	21		22842		AB	774000	1		NPI	1235117524

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
462343653 X	L4111	X YES NO	$ 10448100	$ 000	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (248 566 3313
JEFFREY K WINGATE SIGNATURE ON FILE	S E MICHIGAN SURGICAL HOSP 21230 DEQUINDRE ROAD WARREN MI 48091-2279	SPINE PLLC 2151 WEST 14 MILE BIRMINGHAM MI 480097260
SIGNED 10/8/2016	a. 1750501938	a. 1134329493

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Susan Dixon 11/13/2018 10:48 AM Cathy M. Garrett WAYNE COUNTY CLERK FILED IN MY OFFICE 18-014385-CK

MEDICARE
P O BOX 5533
MARION IL 62959

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [X] (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
							374723080A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
LITTLE MAURICE L	08151964 M [X] F [ ]	LITTLE, MAURICE, L
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1459 ANDREA STREET	Self [X] Spouse [ ] Child [ ] Other [ ]	1459 ANDREA STREET
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
YPSILANTI / MI		YPSILANTI / MI
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
48198 / (313) 718 4781		48198 / ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
LITTLE, MAURICE, L		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
		08151964 M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State) MI	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
		ADJ: SHERRIL KRAUSMAN
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE MM DD YY / QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
02142015		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
DK JEFFREY K WINGATE	1134329493	10052016
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [X] NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. M5416 B. M5126 C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY / To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10052016 10052016	21		22851		AB	414900	1		NPI	1235117524
L4 10052016 10052016	21		63048		AB	432000	1		NPI	1235117524
10052016 10052016	21		38220	59	A	148500	1		NPI	1235117524
10052016 10052016	21		20936		A	145000	1		NPI	1235117524
10052016 10052016	21		20930		A	110000	1		NPI	1235117524
10052016 10052016	21		76000	26	AB	8000	1		NPI	1235117524

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
462343653 [ ] [X]	L4111	[X] YES [ ] NO	$ 125840	$ 000	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
JEFFREY K WINGATE SIGNATURE ON FILE SIGNED 10182016	S E MICHIGAN SURGICAL HOSP 21230 DEQUINDRE ROAD WARREN MI 48091-2279 a. 1750501938	(248) 566 3313 SPINE PLLC 2151 WEST 14 MILE BIRMINGHAM MI 480097260 a. 1134329493

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixson

FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 17J58079
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LITTLE MAURICE L	3. PATIENT'S BIRTH DATE MM DD YY: 08151964 SEX M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): LITTLE, MAURICE, L	
5. PATIENT'S ADDRESS (No., Street): 1459 ANDREA STREET	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street): 1459 ANDREA STREET	
CITY: YPSILANTI STATE: MI	8. RESERVED FOR NUCC USE
CITY: YPSILANTI STATE: MI	
ZIP CODE: 48198 TELEPHONE (Include Area Code): (313) 718 4781	
ZIP CODE: 48198 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO X
a. INSURED'S DATE OF BIRTH MM DD YY: 08151964 SEX M X F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State): MI
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME: ADJ: SHERRIL KRAUSMAN	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE MM DD YY QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JEFFREY K WINGATE	17a. 17b. NPI 1134329493
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 05102016 TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M5416 B. M5126 C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05102016	05102016	22		22612	78	AB	15948 00	1		NPI	1235117524
2 05102016	05102016	22		22842	78	AB	7740 00	1		NPI	1235117524
3 05102016	05102016	22		20680	78	AB	4050 00	1		NPI	1235117524
4 05102016	05102016	22		38220	59,78	A	1485 00	1		NPI	1235117524
5 05102016	05102016	22		20936	78	A	1450 00	1		NPI	1235117524
6 05102016	05102016	22		20930	78	A	1100 00	1		NPI	1235117524

25. FEDERAL TAX I.D. NUMBER: 462343653	SSN EIN: X	26. PATIENT'S ACCOUNT NO.: L4111	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE: $ 31773 00	29. AMOUNT PAID: $ 0 00	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JEFFREY K WINGATE
SIGNATURE ON FILE
SIGNED: DATE: 06012016

32. SERVICE FACILITY LOCATION INFORMATION
S E MICHIGAN SURGICAL HOSP
21230 DEQUINDRE ROAD
WARREN MI 48091-2279
a. 1750501938 b.

33. BILLING PROVIDER INFO & PH # (248)566 3313
SPINE PLLC
2151 WEST 14 MILE
BIRMINGHAM MI 480097260
a. 1134329493 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Susan Dixson 11/13/2018 10:48 AM WAYNE COUNTY CLERK Cathy M. Garrett FILED IN MY OFFICE 18-014385-CK

FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA — CARRIER

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
							17J58079		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY	SEX				4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
LITTLE MAURICE L		08151964	M X F				LITTLE, MAURICE, L		
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED					7. INSURED'S ADDRESS (No., Street)		
1459 ANDREA STREET		Self X Spouse Child Other					1459 ANDREA STREET		
CITY	STATE	8. RESERVED FOR NUCC USE					CITY	STATE	
YPSILANTI	MI						YPSILANTI	MI	
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE	TELEPHONE (Include Area Code)	
48198	(313)718 4781						48198	( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)					a. INSURED'S DATE OF BIRTH MM DD YY	SEX	
		YES X NO					08151964	M X F	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)		
		X YES NO MI							
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?					c. INSURANCE PLAN NAME OR PROGRAM NAME		
		YES X NO					ADJ: SHERRIL KRAUSMAN		
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							YES NO If yes, complete items 9, 9a, and 9d.		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

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SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI 1134329493	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 05102016 TO			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES X NO	$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE	ORIGINAL REF. NO.		
A. M5416 B. M5126 C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER			

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
05102016	05102016	22		76000	26,78	A	8000	1		NPI	1235117524
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
462343653	X	L4111	X YES NO	$ 8000	$ 000	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (248)566 3313
JEFFREY K WINGATE SIGNATURE ON FILE SIGNED 06012016 DATE	S E MICHIGAN SURGICAL HOSP 21230 DEQUINDRE ROAD WARREN MI 48091-2279 a. 1750501938 b.	SPINE PLLC 2151 WEST 14 MILE BIRMINGHAM MI 480097260 a. 1134329493 b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — CR061653 — APPROVED OMB-0938-1197 FORM 1500 (02-12)

Susan Dixson 11/13/2018 10:48 AM WAYNE COUNTY CLERK Cathy M. Garrett FILED IN MY OFFICE 18-014385-CK

FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 17J58079
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LITTLE MAURICE L	3. PATIENT'S BIRTH DATE MM DD YY: 08151964 SEX M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): LITTLE, MAURICE, L	
5. PATIENT'S ADDRESS (No., Street): 1459 ANDREA STREET	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street): 1459 ANDREA STREET	
CITY: YPSILANTI STATE: MI	8. RESERVED FOR NUCC USE
CITY: YPSILANTI STATE: MI	
ZIP CODE: 48198 TELEPHONE (Include Area Code): (313)718 4781	
ZIP CODE: 48198 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO X
a. INSURED'S DATE OF BIRTH MM DD YY: 08151964 SEX M X F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State): MI
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME: ADJ: SHERRIL KRAUSMAN	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02142015 QUAL. 431	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JEFFREY K WINGATE	17a. 17b. NPI 1134329493
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0 A. M5022 B. C. D. E. F. G. H. I. J. K.	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10022015	10022015	11		99245		A	120 00	1		NPI	1235117524
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 462343653	SSN EIN: X	26. PATIENT'S ACCOUNT NO.: L4111	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE: $ 120 00	29. AMOUNT PAID: $ 0 00	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JEFFREY K WINGATE
SIGNATURE ON FILE
SIGNED: 04082016

32. SERVICE FACILITY LOCATION INFORMATION
SPINE PLLC
2151 EAST 14 MILE RD
BIRMINGHAM MI 48009-7260
a. 1134329493 b.

33. BILLING PROVIDER INFO & PH #: (248)566 3313
SPINE PLLC
2151 WEST 14 MILE
BIRMINGHAM MI 480097260
a. 1134329493 b.

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CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixson

FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)	X
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	17J58079
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	LITTLE MAURICE L
3. PATIENT'S BIRTH DATE MM DD YY / SEX	08151964 / M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	LITTLE, MAURICE, L
5. PATIENT'S ADDRESS (No., Street)	1459 ANDREA STREET
6. PATIENT RELATIONSHIP TO INSURED	Self X Spouse Child Other
7. INSURED'S ADDRESS (No. Street)	1459 ANDREA STREET
CITY / STATE	YPSILANTI / MI
8. RESERVED FOR NUCC USE	
CITY / STATE	YPSILANTI / MI
ZIP CODE / TELEPHONE (Include Area Code)	48198 / (313)718 4781
ZIP CODE / TELEPHONE (Include Area Code)	48198 / ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES X NO
a. INSURED'S DATE OF BIRTH MM DD YY / SEX	08151964 / M X F
b. RESERVED FOR NUCC USE	
b. AUTO ACCIDENT? PLACE (State)	X YES NO MI
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	
c. OTHER ACCIDENT?	YES X NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	ADJ: SHERRIL KRAUSMAN
e. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. CLAIM CODES (Designated by NUCC)	
e. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES NO If yes, complete items 9, 9a, and 9d.

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	02142015 / 431
15. OTHER DATE MM DD YY / QUAL.	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE / 17a / 17b. NPI	DK JEFFREY K WINGATE / 1134329493
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY	FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? / $ CHARGES	YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) / ICD Ind.	0
22. RESUBMISSION CODE / ORIGINAL REF. NO.	
A. M5022 B. M25559 C. D. E. F. G. H. I. J. K. L.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
12112015	12112015	11		99215		AB	103500	1		NPI	1235117524
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	462343653 / EIN X	26. PATIENT'S ACCOUNT NO.	L4111	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	X YES NO
28. TOTAL CHARGE	$ 103500	29. AMOUNT PAID	$ 000	30. Rsvd for NUCC Use	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JEFFREY K WINGATE
SIGNATURE ON FILE
SIGNED 01032016

32. SERVICE FACILITY LOCATION INFORMATION
SPINE PLLC
2151 EAST 14 MILE RD
BIRMINGHAM MI 48009-7260
a. 1134329493 b.

33. BILLING PROVIDER INFO & PH # (248)566 3313
SPINE PLLC
2151 WEST 14 MILE
BIRMINGHAM MI 480097260
a. 1134329493 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
X (Medicare#) ( ) (Medicaid#) ( ) (ID#/DoD#) ( ) (Member ID#) ( ) (ID#) ( ) (ID#) X (ID#)	17J58079
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LITTLE MAURICE L	3. PATIENT'S BIRTH DATE MM DD YY: 08151964 SEX: M X F ( )
4. INSURED'S NAME (Last Name, First Name, Middle Initial): LITTLE, MAURICE, L	
5. PATIENT'S ADDRESS (No., Street): 1459 ANDREA STREET	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse ( ) Child ( ) Other ( )
7. INSURED'S ADDRESS (No., Street): 1459 ANDREA STREET	
CITY: YPSILANTI STATE: MI	8. RESERVED FOR NUCC USE
CITY: YPSILANTI STATE: MI	
ZIP CODE: 48198 TELEPHONE (Include Area Code): (313) 718 4781	
ZIP CODE: 48198 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES ( ) NO X
a. INSURED'S DATE OF BIRTH MM DD YY: 08151964 SEX: M X F ( )	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO ( ) PLACE (State): MI
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ( ) NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME: ADJ: SHERRIL KRAUSMAN	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02142015 QUAL. 431
15. OTHER DATE MM DD YY QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JEFFREY K WINGATE
17a.
17b. NPI: 1134329493
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. M5416 B. M5126 C. D. E. F. G. H. I. J. K.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
03222016	03222016	21		22633		A	18477 00	1		NPI	1235117524
03222016	03222016	21		63042	59,50	A	26064 00	1		NPI	1235117524
03222016	03222016	21		22830		AB	8064 00	1		NPI	1235117524
03222016	03222016	21		22842	59	AB	7740 00	1		NPI	1235117524
03222016	03222016	21		22852	59	AB	5236 00	1		NPI	1235117524
03222016	03222016	21		22634		AB	10080 00	2		NPI	1235117524

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
462343653		X	L4111	X YES ( ) NO	$ 75661 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
I certify that the statements on the reverse apply to this bill and are made a part thereof.
JEFFREY K WINGATE
SIGNATURE ON FILE
SIGNED 04082016 DATE

32. SERVICE FACILITY LOCATION INFORMATION
S E MICHIGAN SURGICAL HOSP
21230 DEQUINDRE ROAD
WARREN MI 48091-2279
a. 1750501938 b.

33. BILLING PROVIDER INFO & PH # (248) 566 3313
SPINE PLLC
2151 WEST 14 MILE
BIRMINGHAM MI 480097260
a. 1134329493 b.

PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION CARRIER

Susan Dixson 11/13/2018 10:48 AM WAYNE COUNTY CLERK Cathy M. Garrett FILED IN MY OFFICE 18-014385-CK

FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA — CARRIER

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
					X		17J58079

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
LITTLE MAURICE L	08151964 M X F	LITTLE, MAURICE, L
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1459 ANDREA STREET	Self X Spouse Child Other	1459 ANDREA STREET
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
YPSILANTI MI		YPSILANTI MI
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
48198 (313) 718 4781		48198 ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
	YES X NO	08151964 M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	X YES NO MI	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	ADJ: SHERRIL KRAUSMAN
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 02142015 QUAL. 431	15. OTHER DATE MM DD YY QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK JEFFREY K WINGATE	17a. 17b. NPI 1134329493	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? $ CHARGES YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M5416 B. M5126 C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
03222016	03222016	21		22612		AB	1594 00	1		NPI	1235117524
03222016	03222016	21		22851		AB	1244 00	3		NPI	1235117524
03222016	03222016	21		63044	50	AB	3006 00	1		NPI	1235117524
03222016	03222016	21		20680	59	A	405 00	1		NPI	1235117524
03222016	03222016	21		38220	59	A	1485 00	1		NPI	1235117524
03222016	03222016	21		20936		A	145 00	1		NPI	1235117524

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
462343653 X	L4111	X YES NO	$ 3838 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (248) 566 3313
JEFFREY K WINGATE SIGNATURE ON FILE SIGNED 04082016 DATE	S E MICHIGAN SURGICAL HOSP 21230 DEQUINDRE ROAD WARREN MI 48091-2279 a. 1750501938 b.	SPINE PLLC 2151 WEST 14 MILE BIRMINGHAM MI 480097260 a. 1134329493 b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

FARM BUREAU
P O BOX 30100
LANSING MI 48909

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) / (Medicaid#) / (ID#/DoD#) / (Member ID#) / (ID#) / (ID#) / X (ID#)	17J58079
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LITTLE MAURICE L	3. PATIENT'S BIRTH DATE MM DD YY: 08151964 SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): LITTLE, MAURICE, L	
5. PATIENT'S ADDRESS (No., Street): 1459 ANDREA STREET	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street): 1459 ANDREA STREET	
CITY: YPSILANTI STATE: MI	8. RESERVED FOR NUCC USE
CITY: YPSILANTI STATE: MI	
ZIP CODE: 48198 TELEPHONE (Include Area Code): (313) 718 4781	
ZIP CODE: 48198 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES NO X
a. INSURED'S DATE OF BIRTH MM DD YY: 08151964 SEX: M X F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State): MI
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME: ADJ: SHERRIL KRAUSMAN	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02142015 QUAL: 431	15. OTHER DATE MM DD YY QUAL:
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JEFFREY K WINGATE	17a. 17b. NPI: 1134329493
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0 A. M5416 B. M5126 C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
03222016	03222016	21		20930		A	1100 00	1		NPI	1235117524
03222016	03222016	21		76000	26	A	80 00	1		NPI	1235117524
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
462343653	X	L4111	X YES NO	$ 1180 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (248) 566 3313
JEFFREY K WINGATE SIGNATURE ON FILE SIGNED: 04082016 DATE:	S E MICHIGAN SURGICAL HOSP 21230 DEQUINDRE ROAD WARREN MI 48091-2279 a. 1750501938 b.	SPINE PLLC 2151 WEST 14 MILE BIRMINGHAM MI 480097260 a. 1134329493 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR051653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixon

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) (Medicaid#) (ID/DoD#) (Member ID#) (ID#) (ID#) (ID#)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE
SIGNED / DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE MM DD YY / QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI 1134329493	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY / To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
03222016 03222016	21		22851	AB	1244 00	3		NPI	1235117524
03222016 03222016	21		63044 59	AB	9018 00	3		NPI	1235117524
03222016 03222016	21		38220 59	A	1488 00	1		NPI	1235117524
03222016 03222016	21		20936	A	1488 00	1		NPI	1235117524
03222016 03222016	21		20931	A	1488 00	1		NPI	1235117524
03222016 03222016	21		64493 26	A	80 00	1		NPI	1235117524

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED / DATE	32. SERVICE FACILITY LOCATION INFORMATION a. / b.		33. BILLING PROVIDER INFO & PH # ( ) BIRMINGHAM MI 480097260 1134329493 a. / b.		

PHYSICIAN OR SUPPLIER INFORMATION PATIENT AND INSURED INFORMATION CARRIER

Susan Dixon 11/13/2018 10:48 AM WAYNE COUNTY CLERK Cathy M. Garrett FILED IN MY OFFICE 18-014385-CK

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
	M F	

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
	( )		( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F

b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE MM DD YY / QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES NO	$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind.)	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A B C D E F G H I J K L		

	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
03222016	03222016	21		22633		A	184700	1		NPI	1235117524
03222016	03222016	21		63042	59,50	A	2606400	1		NPI	1235117524
03222016	03222016	21		22845		AB	1302300	1		NPI	1235117524
03222016	03222016	21		22630	59	AB	504400	1		NPI	1235117524
03222016	03222016	21		22852	59	AB	523600	1		NPI	1235117524
03222016	03222016	21		22634		AB	1008600	2		NPI	1235117524

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )

SIGNED DATE a. b. a. b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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Exhibit 3C

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixson

Report Date: 4/11/2018 SUMMIT MEDICAL GROUP PLLC Page: 1

Patient Visit Report - From 05/09/2016 To 05/09/2017 - Office: -- All -- - Provider: Won Chae, MD - Insurance: All - Patient ID: 56235052

Date of Service	POS	CPT	A	B	C	D	Days or Units	Charges	Insurance Payment	Patient Payment	Adj.	Balance
Patient: LITTLE, MAURICE							Patient ID: 56235052		Sex: M		DOB: 8/15/1964	
Insurance: Farm Bureau								Provider: Won Chae, MD			Office:	
6/29/2016	11	73502	RT				1	$140.00	$0.00	$0.00	$0.00	$140.00
		Sub Total:						**$140.00**	**$0.00**	**$0.00**	**$0.00**	**$140.00**
Patient: LITTLE, MAURICE							Patient ID: 56235052		Sex: M		DOB: 8/15/1964	
Insurance: Farm Bureau								Provider: Won Chae, MD			Office:	
7/17/2016	11	72100					1	$130.00	$0.00	$0.00	$0.00	$130.00
		Sub Total:						**$130.00**	**$0.00**	**$0.00**	**$0.00**	**$130.00**
Patient Count: 1							Report Total:	**$270.00**	**$0.00**	**$0.00**	**$0.00**	**$270.00**

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Exhibit 3D

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SUMMIT MEDICAL GROUP

Individual Patient Balance Form

Release date through	04/11/18
Name:	Maurice Little
Date of Birth:	08/15/64

Department Balances (By Taxpayer Identification Number)

TIN:	Department:	Balance:
80058968	SMG- Dr. Jankowski	$117,219.00
	SMG- Dr. Jankowski Rx	$3,821.50
	Summit Medical Group - TOTAL	**$121,040.50**
80058968	SMG-Physical Therapy	**$4,700.00**

COMBINED TOTAL (From All Tax Entities): **$138,306.50**

*Please request all billing ledgers from SMG Lead Contacts 48 hours prior to all settlement conferences.
*Balances may change all the time as treatment may be ongoing.
*Please notify lead contacts ASAP if future benefits are going to be released.

SMG Lead Contacts

Name	Contact Details:
T. Weaver	(Phone) 313.581.3255 (Fax) 313.581.3755 (Email) tweaver@summitgroupmd.com
L. Maracle	(Phone) 313.334.388 (Fax) 313.334.4318 (Email) lmaracle@summitgroupmd.com

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Exhibit 3E

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixson

Statement Date
May 4, 2015

Getter Done Medical Transportation L.L.C
P.O. Box 862
Dearborn Heights, MI 48127
T: (248) 430-4831 F: (248) 430-4832

EIN: 27-4539683
Claim No.: 0001522918

To Whom It May Concern:
Re: Maurice Little
Enclosed is the medical transportation billing.

DOS	Pick-up Location	Drop-off Location	Mileage	Charge	Round Trip	Type of Visit
03-04-15	1459 Andrea Ypsilanti, MI 48198	8560 N Silvery Ln Dearborn Heights, MI 48127	48	$150.00	YES	MRI
03-11-15	1459 Andrea Ypsilanti, MI 48198	1678 Merriman Rd Westland, MI 48186	34	$95.00	YES	Dr. Lemer
03-13-15	1459 Andrea Ypsilanti, MI 48198	1678 Merriman Rd Westland, MI 48186	34	$95.00	YES	Dr. Lemer

Additional drop off location(s) is an additional charge of $32.50

- $65.00 Flat rate (0.1 Miles – 20 Miles)
- $95.00 Flat Rate (21Miles – 45 Miles)
- $150.00 Flat Rate (46Miles – Up to 75 Miles)

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixson

Statement Date	Inv. #
4/13/2016	413163

Getter Done Transportation L.L.C.
P.O. Box 15
Hazel Park, MI 48030
Billing Telephone: (248) 946-1919
Email: getterdonetrans.royaloak@gmail.com

EIN: 27- 4539683
Patient Name: MAURICE LITTLE
Claim No.: 17J58079
Insurer: FARM BUREAU
PO Box 3011, Lansing MI 48909

To Whom It May Concern:
Enclosed is new and outstanding medical transportation billing.

DOS	Pick - up Location	Drop - off Location	Mileage	Charge	Round Trip	Type of Visit	Inv. #
5/29/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	$95.00	YES	Physical Therapy	NEW - 413163
6/3/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	$95.00	YES	Physical Therapy	NEW - 413163
6/5/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	$95.00	YES	Physical Therapy	NEW - 413163
6/8/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	$95.00	YES	Physical Therapy	NEW - 413163
6/10/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	$95.00	YES	Office Visit	NEW - 413163
6/12/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	$95.00	YES	Physical Therapy	NEW - 413163
6/15/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	$95.00	YES	Physical Therapy	NEW - 413163
6/17/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	29.8	$95.00	YES	Physical Therapy	NEW - 413163
6/22/15	27207 Lahser Southfield, MI 48034	1459 Andrea St., Ypsilanti, MI 48198	33.1	$95.00	NO	Physical Therapy	NEW - 413163
6/22/15	1678 Merriman Rd., Westland, MI 48186	27207 Lahser Southfield, MI 48034	18.2	$32.50	NO	Physical Therapy	NEW - 413163
6/22/15	1459 Andrea St., Ypsilanti, MI 48198	1678 Merriman Rd., Westland, MI 48186	14.9	$32.50	NO	Physical Therapy	NEW - 413163

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6/25/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
6/29/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
6/30/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/2/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/6/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/7/15	1459 Andrea St., Ypsilanti, MI 48198	8560 N. Silvery Lane, Dearborn Heights, MI 48127	49	$150.00	YES	MRI	NEW - 413163
7/8/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/9/15	1459 Andrea St., Ypsilanti, MI 48198	8560 N. Silvery Lane, Dearborn Heights, MI 48127	24.5	$95.00	NO	Office Visit	NEW - 413163
7/9/15	8560 N. Silvery Lane, Dearborn Heights, MI 48127	27207 Lahser Southfield, MI 48034	10.9	$32.50	NO	Physical Therapy	NEW - 413163
7/10/15	1459 Andrea St., Ypsilanti, MI 48198	8560 N. Silvery Lane, Dearborn Heights, MI 48127	49	$150.00	YES	MRI	NEW - 413163
7/13/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/14/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	33.1	$95.00	NO	Physical Therapy	NEW - 413163
7/14/15	27207 Lahser Southfield, MI 48034	8560 N. Silvery Lane, Dearborn Heights, MI 48127	10.9	$32.50	NO	Office Visit	NEW - 413163
7/14/15	8560 N. Silvery Lane, Dearborn Heights, MI 48127	1459 Andrea St., Ypsilanti, MI 48198	24.5	$95.00	NO	Office Visit	NEW - 413163
7/15/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/20/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/22/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/23/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163

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7/27/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/28/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/29/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
7/31/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
8/5/15	1459 Andrea St., Ypsilanti, MI 48198	26025 Lahser Rd., Southfield, MI 48033	66.8	$150.00	YES	Office Visit	NEW - 413163
9/2/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
9/8/15	33000 Annapolis Ave., Wayne, MI 48184	27207 Lahser Southfield, MI 48034	23	$95.00	NO	Physical Therapy	NEW - 413163
9/8/15	1459 Andrea St., Ypsilanti, MI 48198	33000 Annapolis Ave., Wayne, MI 48184	14	$32.50	NO	Office Visit	NEW - 413163
9/8/15	27207 Lahser Southfield, MI 48034	1459 Andrea St., Ypsilanti, MI 48198	33.1	$95.00	NO	Physical Therapy	NEW - 413163
9/11/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
9/18/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
9/21/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
9/22/15	1459 Andrea St., Ypsilanti, MI 48198	18101 Oakwood, Dearborn, MI 48124	44.2	$95.00	YES	CT Scan	NEW - 413163
9/23/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
9/25/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
9/29/15	27207 Lahser Southfield, MI 48034	1459 Andrea St., Ypsilanti, MI 48198	33.1	$95.00	NO	Physical Therapy	NEW - 413163
9/29/15	33000 Annapolis Ave., Wayne, MI 48184	27207 Lahser Southfield, MI 48034	23	$95.00	NO	Physical Therapy	NEW - 413163
9/29/15	1459 Andrea St., Ypsilanti, MI 48198	33000 Annapolis Ave., Wayne, MI 48184	14	$32.50	NO	Office Visit	NEW - 413163

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9/30/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
10/2/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	33.1	$95.00	NO	Physical Therapy	NEW - 413163
10/2/15	27207 Lahser Southfield, MI 48034	8560 N. Silvery Lane, Dearborn Heights, MI 48127	10.9	$32.50	NO	Office Visit	NEW - 413163
10/2/15	8560 N. Silvery Lane, Dearborn Heights, MI 48127	1459 Andrea St., Ypsilanti, MI 48198	24.5	$95.00	NO	Physical Therapy	NEW - 413163
10/5/15	8560 N. Silvery Lane, Dearborn Heights, MI 48127	27207 Lahser Southfield, MI 48034	10.9	$32.50	NO	Physical Therapy	NEW - 413163
10/5/15	1459 Andrea St., Ypsilanti, MI 48198	8560 N. Silvery Lane, Dearborn Heights, MI 48127	24.5	$95.00	NO	Office Visit	NEW - 413163
10/5/15	27207 Lahser Southfield, MI 48034	1459 Andrea St., Ypsilanti, MI 48198	33.1	$95.00	NO	Physical Therapy	NEW - 413163
10/7/15	1459 Andrea St., Ypsilanti, MI 48198	27207 Lahser Southfield, MI 48034	66.2	$150.00	YES	Physical Therapy	NEW - 413163
2/19/16	41472 Archwood, Belleville, MI 48111	8560 N. Silvery Lane, Dearborn Heights, MI 48127	35	$95.00	YES	Office Visit	NEW - 413163

Total New Billing:	$6,250.00
Total Previous Billing:	$0.00
Total Amount Outstanding:	**$6,250.00**

Additional drop off location(s) is an additional charge of $32.50

- $65.00 Flat Rate (0.1 Miles - 20 Miles)
- $95.00 Flat Rate (21 Miles - 45 Miles)
- $150.00 Flat Rate (46 Miles - Up to 75 Miles)

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Statement Date	Inv. #
5/26/2016	525165

Getter Done Transportation L.L.C.
P.O. Box 15
Hazel Park, MI 48030
Billing Telephone: (248) 946-1919
Email: getterdonetrans.royaloak@gmail.com

EIN: 27- 4539683
Patient Name: MAURICE LITTLE
Claim No.: 17J58079
Insurer: FARM BUREAU
PO Box 3011, Lansing MI 48909

To Whom It May Concern:
Enclosed is new and outstanding medical transportation billing.

DOS	Pick - up Location	Drop - off Location	Mileage	Charge	Round Trip	Type of Visit	Inv. #
03/11/16	1459 Andrea St, Ypsilanti, MI 48198	8560 N Silvery Ln, Dearborn Heights, MI 48127	49	$150.00	YES	MRI	525165

Total New Billing:	$150.00
Total Previous Billing:	$6,250.00
Total Amount Outstanding:	**$6,400.00**

Additional drop off location(s) is an additional charge of $32.50

- $65.00 Flat Rate (0.1 Miles - 20 Miles)
- $95.00 Flat Rate (21 Miles - 45 Miles)
- $150.00 Flat Rate (46 Miles - Up to 75 Miles)

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixson

Statement Date	Inv. #
1/10/2017	110171

Getter Done Transportation L.L.C.
P.O. Box 15
Hazel Park, MI 48030
Billing Telephone: (248) 946-1919
Email: getterdonetrans.royaloak@gmail.com

EIN: 27- 4539683
Patient Name: MAURICE LITTLE
Claim No.: 17J58079
Insurer: FARM BUREAU
PO Box 3011, Lansing MI 48909

To Whom It May Concern:
Enclosed is new and outstanding medical transportation billing.

DOS	Pick - up Location	Drop - off Location	Mileage	Charge	Round Trip	Type of Visit	Inv. #
07/14/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne, MI 48184	28	$95.00	YES	PHYS THERAPY	110171
07/18/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne, MI 48184	28	$95.00	YES	PHYS THERAPY	110171
07/26/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne, MI 48184	28	$95.00	YES	PHYS THERAPY	110171
07/28/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne, MI 48184	28	$95.00	YES	PHYS THERAPY	110171
08/23/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne, MI 48184	28	$95.00	YES	PHYS THERAPY	110171

Total New Billing:	$475.00
Total Previous Billing:	$6,400.00
Total Amount Outstanding:	**$6,875.00**

Additional drop off location(s) is an additional charge of $32.50

- $65.00 Flat Rate (0.1 Miles - 20 Miles)
- $95.00 Flat Rate (21 Miles - 45 Miles)
- $150.00 Flat Rate (46 Miles - Up to 75 Miles)

Scanned by Susan Dixson 11/13/2018 10:48 AM WAYNE COUNTY CLERK Cathy M. Garrett FILED IN MY OFFICE 18-014385-CK

Statement Date	Inv. #
5/7/2017	507172

Getter Done Transportation L.L.C.
P.O. Box 15
Hazel Park, MI 48030
Billing Telephone: (248) 946-1919
Email: getterdonetrans.royaloak@gmail.com

EIN: 27- 4539683
Patient Name: MAURICE LITTLE
Claim No.: 17J58079
Insurer: FARM BUREAU
PO Box 3011, Lansing MI 48909

To Whom It May Concern:
Enclosed is new and medical transportation billing.

DOS	Pick - up Location	Drop - off Location	Mileage	Charge	Round Trip	Type of Visit	Inv. #
08/23/16	1459 Andrea St, Ypsilanti, MI 48198	33000 Annapolis Ave, Wayne MI 48184	28	$150.00	YES	Office Visit	507172
11/22/16	33000 Annapolis Ave, Wayne MI 48184	1459 Andrea St, Ypsilanti, MI 48198	14	$90.00	NO	Office Visit	507172

Total New Billing:	$240.00
Total Previous Billing:	$6,400.00
Total Amount Outstanding:	**$6,640.00**

Additional drop off location(s) is an additional charge of $45.00

- $90.00 Flat Rate (0.1 Miles - 20 Miles)
- $150.00 Flat Rate (21 Miles - 45 Miles)
- $210.00 Flat Rate (46 Miles - Up to 75 Miles)

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Exhibit 3F

18-014385-CK FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 11/13/2018 10:48 AM Susan Dixson

Account: MAURICE LITTLE, 396119

P Bal	I Bal	W Bal	C Bal	Total
.00	.00	.00	.00	.00

Demographics Transactions Comments

New Search Cancel Help

Search criteria: CRA; Account: 396119; All; Payer Status: All; Pymt Status: All; Detail; Sort by: Date of Service, Ascending; Separate Open and Paid; Exclude Corrections, ATR0;

Change Search

Transactions

Charge #	Date	Patient	Prov	POS	Trans/Mod	Pri Dx	Amount	P/A Total	Due	Due From
343654	09/08/2015	MAURICE	KCL	OFF	73510	71595	140.00	140.00	.00	FAR7/IO
Adj	09/08/2015				ATTY			140.00		
343658	09/08/2015	MAURICE	KCL	OFF	99243	71595	500.00	500.00	.00	FAR7/IO
Adj	09/08/2015				ATTY			500.00		
343652	09/29/2015	MAURICE	KCL	OFF	99213	71595	250.00	250.00	.00	FAR7/IO
Adj	09/29/2015				ATTY			250.00		
343655	10/21/2015	MAURICE	KCL	ANNOP	27130/RT	71525/M166	4980.00	4980.00	.00	FAR7/IO
Adj	10/21/2015				ATTY			4980.00		
343657	10/28/2015	MAURICE	KCL	OFF	97110	71945/M25551	110.00	110.00	.00	FAR7/IO
Adj	10/28/2015				ATTY			110.00		
343659	10/28/2015	MAURICE	KCL	OFF	97001	71945/M25551	260.00	260.00	.00	FAR7/IO
Adj	10/28/2015				ATTY			260.00		
343660	10/28/2015	MAURICE	KCL	OFF	97014	71945/M25551	75.00	75.00	.00	FAR7/IO
Adj	10/28/2015				ATTY			75.00		
343661	10/28/2015	MAURICE	KCL	OFF	97010	71945/M25551	40.00	40.00	.00	FAR7/IO
Adj	10/28/2015				ATTY			40.00		
343662	11/02/2015	MAURICE	KCL	OFF	97110	71945/M25551	220.00	220.00	.00	WSTI/IO
Adj	11/02/2015				ATTY			220.00		
343663	11/02/2015	MAURICE	KCL	OFF	97140	71945/M25551	220.00	220.00	.00	FAR7/IO
Adj	11/02/2015				ATTY			220.00		
343664	11/02/2015	MAURICE	KCL	OFF	97014	71945/M25551	75.00	75.00	.00	WSTI/IO
Adj	11/02/2015				ATTY			75.00		
344746	11/03/2015	MAURICE	KCL	OFF	99024/NC	71525/M166	.00	.00	.00	FAR7/IO
344747	11/03/2015	MAURICE	KCL	OFF	73510	71525/M166	140.00	140.00	.00	FAR7/IO
Adj	11/03/2015				ATTY			140.00		
343665	11/06/2015	MAURICE	KCL	OFF	97110	71945/M25551	220.00	220.00	.00	WSTI/IO
Adj	11/06/2015				ATTY			220.00		
343666	11/06/2015	MAURICE	KCL	OFF	97140	71945/M25551	110.00	110.00	.00	FAR7/IO
Adj	11/06/2015				ATTY			110.00		
343667	11/06/2015	MAURICE	KCL	OFF	97014	71945/M25551	75.00	75.00	.00	FAR7/IO
Adj	11/06/2015				ATTY			75.00		
343668	11/06/2015	MAURICE	KCL	OFF	97010	71945/M25551	40.00	40.00	.00	FAR7/IO
Adj	11/06/2015				ATTY			40.00		
343669	11/09/2015	MAURICE	KCL	OFF	97110	71945/M25551	220.00	220.00	.00	WSTI/IO
Adj	11/09/2015				ATTY			220.00		

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343670 11/09/2015 MAURICE KCL	OFF	97140	71945/M25551	220.00	220.00	.00 FAR7/IO
Adj 11/09/2015		ATTY			220.00	
343671 11/09/2015 MAURICE KCL	OFF	97014	71945/M25551	75.00	75.00	.00 FAR7/IO
Adj 11/09/2015		ATTY			75.00	
343672 11/11/2015 MAURICE KCL	OFF	97110	71945/M25551	220.00	220.00	.00 FAR7/IO
Adj 11/11/2015		ATTY			220.00	
343673 11/11/2015 MAURICE KCL	OFF	97140	71945/M25551	220.00	220.00	.00 FAR7/IO
Adj 11/11/2015		ATTY			220.00	
343674 11/11/2015 MAURICE KCL	OFF	97014	71945/M25551	75.00	75.00	.00 FAR7/IO
Adj 11/11/2015		ATTY			75.00	
343675 11/16/2015 MAURICE KCL	OFF	97110	71945/M25551	110.00	110.00	.00 WSTI/IO
Adj 11/16/2015		ATTY			110.00	
343676 11/16/2015 MAURICE KCL	OFF	97140	71945/M25551	110.00	110.00	.00 WSTI/IO
Adj 11/16/2015		ATTY			110.00	
343677 11/16/2015 MAURICE KCL	OFF	97112	71945/M25551	120.00	120.00	.00 FAR7/IO
Adj 11/16/2015		ATTY			120.00	
343678 11/16/2015 MAURICE KCL	OFF	97014	71945/M25551	75.00	75.00	.00 FAR7/IO
Adj 11/16/2015		ATTY			75.00	
343679 11/16/2015 MAURICE KCL	OFF	97010	71945/M25551	40.00	40.00	.00 FAR7/IO
Adj 11/16/2015		ATTY			40.00	
341494 11/17/2015 MAURICE KCS	OFF	99024/NC	71525/M166	.00	.00	.00 WSTI/IO
344756 12/03/2015 MAURICE KCL	OFF	99213	71945/M25551	250.00	250.00	.00 FAR7/IO
Adj 12/03/2015		ATTY			250.00	
344757 12/03/2015 MAURICE KCL	OFF	73510	71945/M25551	140.00	140.00	.00 FAR7/IO
Adj 12/03/2015		ATTY			140.00	
343322 12/21/2015 MAURICE KCL	SIMI	27134/78RT	72810/M619	6630.00	6630.00	.00 FAR7/IO
Adj 12/21/2015		ATTY			6630.00	
343323 12/21/2015 MAURICE KCL	SIMI	27062/7859	72810/M619	1510.00	1510.00	.00 FAR7/IO
Adj 12/21/2015		ATTY			1510.00	
347094 01/19/2016 MAURICE KCL	OFF	99024/NC	71525/M166	.00	.00	.00 FAR7/IO
347095 01/19/2016 MAURICE KCL	OFF	73502/RT	71525/M166	140.00	140.00	.00 FAR7/IO
Adj 01/19/2016		ATTY			140.00	
347252 02/23/2016 MAURICE KCL	OFF	99213/25	71945/M25551	250.00	250.00	.00 FAR7/IO
Adj 02/23/2016		ATTY			250.00	
347253 02/23/2016 MAURICE KCL	OFF	73565	71945/M25551	130.00	130.00	.00 FAR7/IO
Adj 02/23/2016		ATTY			130.00	
347254 02/23/2016 MAURICE KCL	OFF	20611/RT	71945/M25551	900.00	900.00	.00 FAR7/IO
Adj 02/23/2016		ATTY			900.00	
347255 02/23/2016 MAURICE KCL	OFF	J0702	71945/M25551	70.00	70.00	.00 FAR7/IO
Adj 02/23/2016		ATTY			70.00	
347256 02/23/2016 MAURICE KCL	OFF	73502/RT	7177/M2241	140.00	140.00	.00 FAR7/IO
Adj 02/23/2016		ATTY			140.00	
348953 03/08/2016 MAURICE KCL	OFF	99213	7177/M2241	250.00	250.00	.00 FAR7/IO
Adj 03/08/2016		ATTY			250.00	
349255 03/17/2016 MAURICE KCL	OFF	99213	71946/M25561	250.00	250.00	.00 FAR7/IO

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Transaction Search Results

	Adj 03/17/2016		ATTY			250.00		
352499	04/26/2016 MAURICE KCL	OFF	99214	71946/M25562	370.00	370.00	.00	FAR7/IO
	Adj 04/26/2016		ATTY			370.00		
352500	04/26/2016 MAURICE KCL	OFF	73502/RT	71945/M25551	140.00	140.00	.00	FAR7/IO
	Adj 04/26/2016		ATTY			140.00		
352501	04/26/2016 MAURICE KCL	OFF	73560/RT	71946/M25562	110.00	110.00	.00	FAR7/IO
	Adj 04/26/2016		ATTY			110.00		
352502	04/26/2016 MAURICE KCL	OFF	73560/LT	71946/M25562	110.00	110.00	.00	FAR7/IO
	Adj 04/26/2016		ATTY			110.00		
354117	05/17/2016 MAURICE CLT	OFF	99213	71946/M25561	250.00	250.00	.00	FAR7/IO
	Adj 05/17/2016		ATTY			250.00		
355431	06/16/2016 MAURICE CLT	OFF	99213	71946/M25561	250.00	250.00	.00	FAR7/IO
	Adj 06/16/2016		ATTY			250.00		
355432	06/16/2016 MAURICE CLT	OFF	73502/RT	72810/M619	140.00	140.00	.00	FAR7/IO
	Adj 06/16/2016		ATTY			140.00		
356610	07/07/2016 MAURICE CLT	OFF	99213	71525/M166	250.00	250.00	.00	FAR7/IO
	Adj 07/07/2016		ATTY			250.00		
357056	07/12/2016 MAURICE SLT	OFF	97001	71945/M25551	260.00	260.00	.00	FAR7/IO
	Adj 07/20/2016		ATTY			260.00		
357057	07/12/2016 MAURICE SLT	OFF	97110	71945/M25551	110.00	110.00	.00	FAR7/IO
	Adj 07/20/2016		ATTY			110.00		
357058	07/14/2016 MAURICE SLT	OFF	97110	71945/M25551	220.00	220.00	.00	FAR7/IO
	Adj 07/20/2016		ATTY			220.00		
357059	07/14/2016 MAURICE SLT	OFF	97140	71945/M25551	220.00	220.00	.00	FAR7/IO
	Adj 07/20/2016		ATTY			220.00		
357060	07/14/2016 MAURICE SLT	OFF	97014	71945/M25551	75.00	75.00	.00	FAR7/IO
	Adj 07/20/2016		ATTY			75.00		
357719	07/18/2016 MAURICE CLT	OFF	97110	71945/M25551	220.00	220.00	.00	FAR7/IO
	Adj 07/18/2016		ATTY			220.00		
357720	07/18/2016 MAURICE CLT	OFF	97140	71945/M25551	110.00	110.00	.00	FAR7/IO
	Adj 07/18/2016		ATTY			110.00		
357721	07/18/2016 MAURICE CLT	OFF	G0283	71945/M25551	75.00	75.00	.00	FAR7/IO
	Adj 07/18/2016		ATTY			75.00		
358019	07/26/2016 MAURICE CLT	OFF	97110	71945/M25551	220.00	220.00	.00	FAR7/IO
	Adj 07/26/2016		ATTY			220.00		
358020	07/26/2016 MAURICE CLT	OFF	97140	71945/M25551	110.00	110.00	.00	FAR7/IO
	Adj 07/26/2016		ATTY			110.00		
358021	07/26/2016 MAURICE CLT	OFF	97014	71945/M25551	75.00	75.00	.00	FAR7/IO
	Adj 07/26/2016		ATTY			75.00		
358329	07/28/2016 MAURICE CLT	OFF	99213	71525/M166	250.00	250.00	.00	FAR7/IO
	Adj 07/28/2016		ATTY			250.00		
			Totals		**23165.00**	**23165.00**	**.00**	

62 matches found

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Kevin T Crawford, D.O., PC

Patient Procedure Summary

MAURICE LITTLE (14461)

DOS	Description	Expected	Charges	Adjust	Receipts	Pat. Balance	Ins. Balance	Total Balance
	MAURICE LITTLE							
08/11/2016	99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAN	-	250.00	-	-	-	250.00	250.00
08/23/2016	99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAN	-	250.00	-	-	-	250.00	250.00
08/23/2016	E0747 - Elec osteogen stim not spine	-	6,500.00	-	-	-	6,500.00	6,500.00
11/22/2016	73502 - RADEX HIP UNILATERAL WITH PELVIS 2-3 VIEWS	-	140.00	-	-	-	140.00	140.00
11/22/2016	73560 - RADIOLOGIC EXAM, KNEE; 1/2 VIEWS	-	110.00	-	-	-	110.00	110.00
11/22/2016	73565 - RADIOLOGIC EXAM, KNEE; BOTH KNEES, STANDING, ANTEROPOSTERIOR	-	130.00	-	-	-	130.00	130.00
11/22/2016	99214 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: DETAILED HX; DETAILED EXAM; MED DECISION MOD COMPLEXITY	-	370.00	-	-	-	370.00	370.00
11/22/2016	L1833 - Ko adj jnt pos r sup pre ols	-	950.00	-	-	-	950.00	950.00
07/13/2017	73502 - RADEX HIP UNILATERAL WITH PELVIS 2-3 VIEWS	-	140.00	-	-	-	140.00	140.00
07/13/2017	99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAN	-	250.00	-	-	-	250.00	250.00
08/17/2017	72170 - RADIOLOGIC EXAM, PELVIS; 1 OR 2 VIEWS	-	100.00	-	-	-	100.00	100.00
08/17/2017	99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAN	-	250.00	-	-	-	250.00	250.00
03/06/2018	73502 - RADEX HIP UNILATERAL WITH PELVIS 2-3 VIEWS	-	140.00	-	-	-	140.00	140.00
03/13/2018	99213 - OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAN	-	250.00	-	-	-	250.00	250.00
		-	9,830.00	-	-	-	9,830.00	9,830.00

SPG - $20,429
DOPC - $12,566
$32,995

4/11/2018 10:19:18 AM